

Quarterly Claims Settlement Practices Report

The Quarterly Claims Settlement Practices Report is required to be submitted for each licensed health care service plan pursuant to Section 1300.71 and 1300.71.38 of the California Code of Regulations. Health care service plans report claim information if the plan or any of its capitated providers* has failed to timely reimburse at least 95% of complete claims with correct payment including interest and penalties due, that became payable during the reporting period. The following charts summarize the deficiencies reported by the health plans for Q1 through Q4 of 2005.

There are 45 full service health plans and 52 specialized plans. The Department has identified and assigned numbers to 439 capitated providers, of which 211 are classified as RBOs.

(*) Capitated providers include all risk-bearing organizations and any other medical provider that accepts capitation and pays claims.

<u>Full Service Health Plan Deficiencies</u>	<u>Q1- 2005</u>	<u>Q2-2005</u>	<u>Q3-2005</u>	<u>Q4 - 2005</u>
	<u>(1/1/05- 3/31/05)</u>	<u>(4/1/05- 6/30/05)</u>	<u>(7/1/05- 9/30/05)</u>	<u>(10/1/05- 12/31/05)</u>

Total number of health plans that failed to timely reimburse at least 95% (including the activity of all of its claims processing organizations) of complete claims (Commercial and Healthy Families (HMO)) with the correct payment including interest and penalties due and owing, that became due and payable in the reporting period.

2	1	1	1
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Total number of health plans that failed to timely reimburse at least 90% (including the activity of all of its claims processing organizations) of complete claims (Medi-Cal – within 30 days) with the correct payment including interest and penalties due and owing, that became due and payable in the reporting period.

4	4	5	3
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Total number of health plans that failed to timely reimburse at least 90% (including the activity of all of its claims processing organizations) of complete claims (Medi-Cal – within 45 days) with the correct payment including interest and penalties due and owing, that became due and payable in the reporting period.

1	1	1	0
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Disclosure of Emerging Claims Payment Deficiencies:

- Total number of health plans that failed to forward at least 95% of misdirected claims consistent with sections 1300.71(b)(2)(A) and (B) during the reporting period.
- Total number of health plans that failed to accept a late claim consistent with section 1300.71(b)(4) at least 95% of the time during the reporting period.

2	2	2	1
0	0	0	0

<ul style="list-style-type: none"> • Total number of health plans that failed to acknowledge the receipt of at least 95% of the claims consistent with section 1300.71(c) during the reporting period. 	1	0	0	2
<ul style="list-style-type: none"> • Total number of health plans that failed to provide an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with section 1300.71 (d)(1) at least 95% of the time for the affected claims during the reporting period. 	0	0	0	0
<ul style="list-style-type: none"> • Total number of health plans that failed to contest or deny a claim, or portion thereof, within the timeframes of section 1300.71(h) and sections 1371 or 1371.35 of the Act at least 95% of the time for the affected claims during the reporting period. 	1	0	2	3
<ul style="list-style-type: none"> • Total number of health plans that failed to provide the required Notice of Dispute Resolution Mechanism(s) consistent with section 1300.71.38(b) at least 95% of the time for the affected claims during the reporting period. 	0	1	1	0
<ul style="list-style-type: none"> • Total number of health plans that requested reimbursement of an overpayment of a claim inconsistent with the provisions of section 1300.71(b)(5) and (d)(3), (4), (5) and (6) more than 5% of the time for affected claims during the reporting period. 	n/a	n/a	n/a	1
<ul style="list-style-type: none"> • Total number of health plans that rescinded or modified an authorization for health care services, consistent with section 1300.71(a)(8)(T), on three (3) or more occasions during the reporting period. 	n/a	n/a	n/a	0
<ul style="list-style-type: none"> • Total number of health plans that imposed a deadline for the receipt of claims that was less than 90 days after the date of service for contracted providers consistent with section 1300.71(b)(1). 	n/a	n/a	n/a	0
<ul style="list-style-type: none"> • Total number of health plans that imposed a deadline for the receipt of claims that was less than 180 days after the date of service for non-contracted providers consistent with section 1300.71(b)(1). 	n/a	n/a	n/a	0

- Total number of health plans that failed to establish that the request for medical records were required to determine payor liability consistent with section 1300.71(a)(8)(H) over any 12-month period. n/a n/a n/a 0
- Total number of health plans that failed to establish that the requests for medical records were required to determine payor liability for emergency room services consistent with section 1300.71(a)(8)(I) over any 12-month period. n/a n/a n/a 0

Specialized Health Plan Deficiencies

Q1 2005 Q2-2005 Q3-2005 Q4-2005
(1/1/05- (4/1/05- (7/1/05- (10/1/05-
3/31/05) 6/30/05) 9/30/05) 12/31/05)

Total number of health plans that failed to timely reimburse at least 95% (including the activity of all of its claims processing organizations) of complete claims (Commercial and Healthy Families (HMO)) with the correct payment including interest and penalties due and owing, that became due and payable in the reporting period.

0 1 0 1

Total number of health plans that failed to timely reimburse at least 90% (including the activity of all of its claims processing organizations) of complete claims (Medi-Cal – within 45 days) with the correct payment including interest and penalties due and owing, that became due and payable in the reporting period.

0 0 1 0

Total number of health plans that failed to timely reimburse at least 90% (including the activity of all of its claims processing organizations) of complete claims (Medi-Cal – within 30 days) with the correct payment including interest and penalties due and owing, that became due and payable in the reporting period.

0 0 1 0

Disclosure of Emerging Claims Payment Deficiencies:

- Total number of health plans that failed to forward at least 95% of misdirected claims consistent with sections 1300.71(b)(2)(A) and (B) during the reporting period. 0 0 0 0

<ul style="list-style-type: none"> • Total number of health plans that failed to accept a late claim consistent with section 1300.71(b)(4) at least 95% of the time during the reporting period. 	0	0	0	0
<ul style="list-style-type: none"> • Total number of health plans that failed to acknowledge the receipt of at least 95% of the claims consistent with section 1300.71(c) during the reporting period. 	1	2	1	1
<ul style="list-style-type: none"> • Total number of health plans that failed to provide an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with section 1300.71 (d)(1) at least 95% of the time for the affected claims during the reporting period. 	0	0	0	0
<ul style="list-style-type: none"> • Total number of health plans that failed to contest or deny a claim, or portion thereof, within the timeframes of section 1300.71(h) and sections 1371 or 1371.35 of the Act at least 95% of the time for the affected claims during the reporting period. 	0	0	0	0
<ul style="list-style-type: none"> • Total number of health plans that failed to provide the required Notice of Dispute Resolution Mechanism(s) consistent with section 1300.71.38(b) at least 95% of the time for the affected claims during the reporting period. 	1	1	0	0
<ul style="list-style-type: none"> • Total number of health plans that requested reimbursement of an overpayment of a claim inconsistent with the provisions of section 1300.71(b)(5) and (d)(3), (4), (5) and (6) more than 5% of the time for affected claims during the reporting period. 	n/a	n/a	n/a	0
<ul style="list-style-type: none"> • Total number of health plans that rescinded or modified an authorization for health care services, consistent with section 1300.71(a)(8)(T), on three (3) or more occasions during the reporting period. 	n/a	n/a	n/a	0
<ul style="list-style-type: none"> • Total number of health plans that imposed a deadline for the receipt of claims that was less than 90 days after the date of service for contracted providers consistent with section 1300.71(b)(1). 	n/a	n/a	n/a	0

<ul style="list-style-type: none"> Total number of health plans that imposed a deadline for the receipt of claims that was less than 180 days after the date of service for non-contracted providers consistent with section 1300.71(b)(1). 	n/a	n/a	n/a	0
<ul style="list-style-type: none"> Total number of health plans that failed to establish that the request for medical records were required to determine payor liability consistent with section 1300.71(a)(8)(H) over any 12-month period. 	n/a	n/a	n/a	0
<ul style="list-style-type: none"> Total number of health plans that failed to establish that the requests for medical records were required to determine payor liability for emergency room services consistent with section 1300.71(a)(8)(I) over any 12-month period. 	n/a	n/a	n/a	0

Capitated Providers - Claims Payment Deficiencies

	<u>Q1 2005</u> (1/1/05- 3/31/05)	<u>Q2-2005</u> (4/1/05- 6/30/05)	<u>Q3-2005</u> (7/1/05- 9/30/05)	<u>Q4-2005</u> (10/1/05- 12/31/05)
Total number of capitated providers/claims processing organizations, that failed to timely reimburse at least 95% of complete claims (Commercial and Healthy Families (HMO)) with the correct payment including interest and penalties due and owing, that became due and payable in the reporting period.	13	24	28	17
Total number of capitated providers/claims processing organizations, that failed to timely reimburse at least 90% of complete claims (Medi-Cal - within 30 days) with the correct payment including interest and penalties due and owing, that became due and payable in the reporting period.	26	28	31	27
Total number of capitated providers/claims processing organizations, that failed to timely reimburse at least 90% of complete claims (Medi-Cal - within 45 days) with the correct payment including interest and penalties due and owing, that became due and payable in the reporting period.	13	6	14	15

Disclosure of Emerging Claims Payment Deficiencies:

• Total number of capitated providers/claims processing organizations that failed to forward at least 95% of misdirected claims consistent with sections 1300.71(b)(2)(A) and (B) during the reporting period.	17	18	19	11
• Total number of capitated providers/claims processing organizations that failed to accept a late claim consistent with section 1300.71(b)(4) at least 95% of the time during the reporting period.	0	1	0	0
• Total number of capitated providers/claims processing organizations that failed to acknowledge the receipt of at least 95% of the claims consistent with section 1300.71(c) during the reporting period.	23	30	29	23
• Total number of capitated providers/claims processing organizations that failed to provide an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with section 1300.71 (d)(1) at least 95% of the time for the affected claims during the reporting period	3	10	17	49
• Total number of capitated providers/claims processing organizations that failed to contest or deny a claim, or portion thereof, within the timeframes of section 1300.71(h) and sections 1371 or 1371.35 of the Act at least 95% of the time for the affected claims during the reporting period.	16	36	42	20
• Total number of capitated providers/claims processing organizations that failed to provide the required Notice of Dispute Resolution Mechanism(s) consistent with section 1300.71.38(b) at least 95% of the time for the affected claims during the reporting period.	4	6	3	5

<ul style="list-style-type: none"> • Total number of health plans that requested reimbursement of an overpayment of a claim inconsistent with the provisions of section 1300.71(b)(5) and (d)(3), (4), (5) and (6) more than 5% of the time for affected claims during the reporting period. 	0	0	0	0
<ul style="list-style-type: none"> • Total number of health plans that rescinded or modified an authorization for health care services, consistent with section 1300.71(a)(8)(T), on three (3) or more occasions during the reporting period. 	n/a	n/a	n/a	2
<ul style="list-style-type: none"> • Total number of health plans that imposed a deadline for the receipt of claims that was less than 90 days after the date of service for contracted providers consistent with section 1300.71(b)(1). 	n/a	n/a	n/a	0
<ul style="list-style-type: none"> • Total number of health plans that imposed a deadline for the receipt of claims that was less than 180 days after the date of service for non-contracted providers consistent with section 1300.71(b)(1). 	n/a	n/a	n/a	0
<ul style="list-style-type: none"> • Total number of health plans that failed to establish that the request for medical records were required to determine payor liability consistent with section 1300.71(a)(8)(H) over any 12-month period. 	n/a	n/a	n/a	0
<ul style="list-style-type: none"> • Total number of health plans that failed to establish that the requests for medical records were required to determine payor liability for emergency room services consistent with section 1300.71(a)(8)(I) over any 12-month period. 	n/a	n/a	n/a	1

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